2005 COMMONWEALTH OF MASSACHUSETTS HEALTH CARE SPENDING ACCOUNT (HCSA) ENROLLMENT / CHANGE FORM

EMPLOYEE INFORMATION / DIRECT DEPOSIT AUTHORIZATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP

DATE OF BIRTH	☐ SINGLE ☐ MARRIED	WORK PHONE	HOME PHONE	EMAIL ADDRESS

BANK NAME	ROUTING NUMBER	ACCOUNT NUMBER	☐ CHECKING ☐ SAVINGS

Please complete the appropriate box below. See reverse side of this form for additional information.

TO ENROLL IN THE SmartFLEX DEBIT CARD, COMPLETE AND RETURN THE SEPARATE ENROLLMENT FORM, AVAILABLE THROUGH YOUR PAYROLL COORDINATOR AND ON THE GIC'S WEBSITE: WWW.MASS.GOV/GIC.

OPEN ENROLLMENT

☐ **YES** I choose to participate in the HCSA Plan. I authorize my Employer to deduct the amount specified below.

$_____ ANNUAL ELECTION (from $500 to $2,000) will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods in the year: 26 Deduction Amt: _____

NEW HIRE

☐ **YES** I choose to participate in the HCSA Plan. I authorize my Employer to deduct the amount specified below.

$_____ ANNUAL ELECTION (from $500 to $2,000) will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods remaining in the year: _____ Deduction Amt: _____
Date of Hire: _____

CHANGE IN STATUS

Complete this section to add or drop participation in the Health Care Spending Account Plan (HCSA).

☐ **YES** I choose to participate in the HCSA Plan. I authorize my Employer to deduct the amount specified below.

☐ **YES** I choose to cancel my election.

$_____ ANNUAL ELECTION (from $500 to $2,000) will be divided over each pay period during the year

To be completed by Payroll Coordinator:
# of pay periods remaining in the year: _____ Deduction Amt: _____
Change of Status Date: _____

AUTHORIZATION TO PARTICIPATE / CHANGE

I understand that I may not increase or decrease the amount of my income reduction until the next Plan Year, except to reflect a change in my family status. In making contributions to this spending account I understand that I will forfeit any amount in my account if I do not incur eligible expenses for it by the end of the Plan Year. This election replaces any previous election and will terminate on the earlier of (1) the end of the Plan Year; (2) when I am no longer being compensated in an amount at least equal to my total salary reduction; (3) termination of the Plan. My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code. I choose to have my reimbursements made to me via direct deposit. I authorize Sentinel Benefits to make deposits to my bank account indicated above.

SIGNATURE _____ DATE: _____

PAYROLL COORDINATOR VERIFICATION

Effective Payroll Date: _____ Name: _____

Agency Name: _____ Department ID #: _____ / _____

Phone #: _____ Fax #: _____ Email: _____

IMPORTANT INFORMATION REGARDING ENROLLMENT AND CHANGES

Administrative Fee:
The cost to administer this program is paid for by each employee on a before tax basis. The monthly administrative fee is $3.95 – for HCSA alone or HCSA and the Dependent Care Assistance Program (DCAP) combined.

HCSA Annual Maximum:
Beginning plan year January 1, 2005 to December 31, 2005, employees may elect an annual minimum of $500.00 up to a maximum of $2,000.

Eligibility:
Active state employees who are **eligible** for health benefits with the GIC are eligible to participate in the HCSA. Enrollment in a GIC benefit plan is not required. New employee coverage begins on the first day of the month following 60 calendar days from the first date of employment or two calendar months, whichever comes first. Claims incurred after your effective date are eligible for reimbursement. Employees must work at least 18.75 hours per 37.5 hour work week or 20 hours per 40 hour work week to be eligible. You may claim health care expenses under the HCSA plan for you, your spouse and your eligible tax dependents.

Change in Status:
You may change your contribution election at the beginning of each plan year. You may only change your election during the plan year if you can demonstrate a "change in status." Only the following events will be considered a valid change in status under Internal Revenue Service rules:

- Change in legal marital status;
- Change in number of dependents;
- Change in employment status;
- Change in work schedule which changes your eligibility for the program;
- Dependent satisfies or ceases to satisfy eligibility requirements;
- Change of residence or work-site; and
- Judgment, decree or order pertaining to child or spouse.

If you would like to terminate your election as a result of a valid status change, enter a zero dollar amount in the Change in Status section of the enrollment form. Payroll Coordinators must obtain the appropriate documents for a Change in Status, e.g. marriage or birth certificate. If you leave the payroll due to termination of employment or leave without pay and stop contributing to your account, your eligibility in the HCSA plan will be terminated. You will be able to submit claims for expenses that occur on or before your last paycheck deduction. If you return to the payroll during the Plan Year, see your Payroll Coordinator to re-enroll and submit a change in status form. If you terminate employment or go on an unpaid leave of absence, you may be eligible for COBRA. Please see your Payroll Coordinator for your COBRA application.

Signature and Form Submission:
The employee and Payroll Coordinator must sign this form. All forms must be submitted to the Payroll Coordinator at your work site. The Payroll Coordinator must send a copy of the form to Sentinel Benefits. Failure to do so will result in an employee not receiving reimbursement for an eligible health care expense.

Eligible Expenses under a Health Care Spending Account Plan:
Eligible expenses under a HCSA are defined as those that are medically necessary, prescribed by a licensed practitioner and are not reimbursed under another program. A guideline for eligible expenses can be found in Treasury Publication 502 (Medical and Dental Expenses); it is available on the Internet at www.MyFSA.com under Publications and Forms. Important: Keep in mind that expenses such as insurance premiums may be deductible on Schedule A tax return but are not eligible for reimbursement through a HCSA. Some examples of eligible expenses are: Acupuncture, Ambulance, Artificial Limbs, Contact Lenses, Deductibles, Dental Fees, Health & Rx Co-pays, Hearing Aids, Over the Counter (OTC) Drugs (nonprescription nutritional supplements excluded), Orthodontic Treatment, Medically Necessary Smoking Cessation Programs/Treatments, Vaccinations, and more.

***Ineligible* Expenses under a Health Care Spending Account Plan:**
Certain health care expenses are not eligible for reimbursement from your HCSA, some of which are: Cosmetic surgery, Cosmetic procedures, Fitness programs, Hair transplants, Health club memberships, Insurance premiums, and more.